SSI Managed Care Encounter Reporting 2.5 --- Data Dictionary View (HEADER)

This document describes the various data elements contained in the encounter record you will extract and send to the State. The description includes things like data element name, length and data type. In addition, there is a brief definition of the data element as well as some of the validation rules Encounter Reporting will use to verify the data you send us. It's primarily intended as a technical document to assist the MCO IT personnel in creating an extract from your claims history data

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot) / Format	Is data required?	Default Value	ID#	Error cat
Organization ID	8 Fixed	**N** (00000000)	Y	None	H1	H
Data Element Description:	Eight digit certified Medicaid provider number assigned to the MCO. Currently, Community Care Organization Milw Co = 69002300, Elder Care of Dane County = 69002700, Community Living Alliance = 69005000, Community Health Partnership = 69005200					
Validation Rules:	Must exist in the Master Lookup table.					
Submission Date	10 Fixed	D(CCYY-MM-DD)	Y	None	H2	H
Data Element Description:	The date the submission was generated at the MCO.					
Validation Rules:						
Begin Posting Date	10 Fixed	D(CCYY-MM-DD)	Y	None	H3	H
Data Element Description:	The beginning process date used to extract encounter records for the submission.					
Validation Rules:						
End Posting Date	10 Fixed	D(CCYY-MM-DD)	Y	None	H4	H
Data Element Description:	The ending process date used to extract encounter records for the submission.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot) / Format	Is data required?	Default Value	ID#	Error cat
Validation Rules:						
Number of Records Transmitted	8 Max	N	Y	None	H5	H
Data Element Description:	The number of detail records that are contained within the submission.					
Validation Rules:	Number of Records Transmitted must be equal to the number of detail records in a submission.					
CMO:Submission_type	10 Max	A	Y	TEST	H6	H
Data Element Description:	The submission type must be Production					
Validation Rules:	Must be 'Production'. This value is not case sensitive					

SSI Managed Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Record ID	80 Max	ANPlus	Y	None	NA	D04
Data Element Description:	Unique ID assigned by the MCO to uniquely identify the record(claim detail line). This ID is unique to every transaction submitted.					
Validation Rules:						
Claim Status	1 Fixed	A (0)	Y	None	NA	D07
Data Element Description:	The current status of the encounter (claim detail line). (P = Paid; D = Denied)					
Validation Rules:	Must be either P or D.					
Data Source	2 Fixed	AN (00)	Y	01	NA	D03
Data Element Description:	Identifies the source of data. 01 = "Claims / Clinical System", 02 = "ISP", 03 = "Accounts Receivable", 04 = "Predictive Model", and 05 = "Accounts Payable" . Other sources might include the Timekeeping module/Payroll.					
Validation Rules:	Must exist in the Master Lookup table and valid for this organization.					
Member Share	1 Fixed	A (0)	Y	N	NA	D63
Data Element Description:	The type of member's share. Supported services are: C = Cost Share, R = Room & Board, V = Voluntary Contribution, S = Spenddown or N = None.					
Validation Rules:	Must be either "C", "R", "V", "S" or "N".					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Organization ID	8 Fixed	N (00000000)	Y	None	NA	D02
Data Element Description:	Eight digit certified Medicaid provider number assigned to the MCO. Currently, Community Care Organization Milw Co = 69002300, Elder Care of Dane County = 69002700, Community Living Alliance = 69005000, Community Health Partnership = 69005200					
Validation Rules:	Must exist in the Master Lookup table.					
Posting Date	10 Fixed	D (CCYY-MM-DD)	Y	None	Adjudication or Payment Date (AN, L=35)	D59
Data Element Description:	The date the claim was finalized. For paid claims it is the check date. For denied claims, it is the EOB or notification date. For adjustments it is the posting date.					
Validation Rules:						
Record Type	1 Fixed	A (0)	Y	None	NA	D08
Data Element Description:	The type of encounter transaction. O = An unadjusted transaction. C = Adjusting entries that usually come in pairs. The Credit is to reverse the actual transaction being adjusted and the Debit is to "replace" the transaction being adjusted.					
Validation Rules:	Must be O or C					
Support Indicator	1 Fixed	A (0)	Y	C	NA	D62
Data Element Description:	The type of support this service line item represents. S = Self-directed; C = MCO-directed; N = Non-Services					
Validation Rules:	Must be either "C", "N" or "S". Must be "N" for Member share					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Billing Provider Last Name or Organization	35 Max	ANPlus	Y	None	Billing_Provider_Last_ Name_or_Organization (AN, L=35)	D21
Data Element Description:	Last name of the billing provider or the name of the individual group/clinic, or organization.					
Validation Rules:						
From Date of Service	10 Fixed	D (CCYY-MM-DD)	Y	None	Service Date (AN, L=35) From Date and To Date of service are combined into one field on the HIPAA 837 layout	D42
Data Element Description:	First date of service.					
Validation Rules:						
Paid Amount	15 (13,2) Max	N (-9999999999999.99)	Y	None	Payer Paid Amount (AN, L=18)	D58
Data Element Description:	The amount paid by the MCO to the provider. (This is the amount paid for this line item only. If multiple details are being paid on one claim do not enter the total claim paid amount). Example the dollar amount of 35.5 can be sent as 35.5 or 35.50. Field size expanded to 18(15+decimal+2decimals) to comply with HIPAA					
Validation Rules:	Must be less than or equal to Charges.					
Receipt Date	10 Fixed	D (CCYY-MM-DD)	Y	None	NA	D57
Data Element Description:	The date the claim was received by the MCO from the provider.					
Validation Rules:						

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Recipient ID	10 Fixed	N (0000000000)	Y	None	Patient's Primary Identification Number (AN, L=80)	D30
Data Element Description:	Recipient's ten digit Medicaid identification number with no dashes. Fixed length of 10 numbers.					
Validation Rules:	Must exist in the Master Lookup table.					
Recipient First Name	25 Max	ANPlus	Y	None	Patient First Name (AN, L=25)	D32
Data Element Description:	First name of recipient.					
Validation Rules:						
Recipient Last Name	35 Max	ANPlus	Y	None	Patient Last Name (AN, L=35)	D31
Data Element Description:	Last name of recipient.					
Validation Rules:						
Service Delivery Type	2 Fixed	A (00)	Y	None	NA	D76
Data Element Description:	The service delivery mechanism. Examples are PC = Program Contract providers, NC = non-program Contract providers, IS = Informal Supports, PH = Public Health, etc.					
Validation Rules:	Must exist in the Master Lookup table.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
To Date of Service	10 Fixed	D (CCYY-MM-DD)	Y	None	Service Date (AN, L=35) From Date and To Date of service are combined into one field on the HIPAA 837 layout	D43
Data Element Description:	Last date of service.					
Validation Rules:	On Pharmacy Claims, To Date of Service must be less than or equal to Posting Date					
TPL Paid Amount	15 (13,2) Max	N (-9999999999999.99)	Y	None	NA	D60
Data Element Description:	Detail claim amount paid by third party insurer. (This is the TPL amount paid for this line item only. If multiple TPL details are being paid on one claim do not enter the total TPL paid amount). Example the dollar amount of 35.5 can be sent as 35.5 or 35.50. Field size expanded to 18(15+decimal+2decimals) to comply with HIPAA					
Validation Rules:	Must be present for Encounter Transactions. Must equal "0" for Member share transactions.					
Adjustment Type	1 Fixed	A (0)	S	None	NA	D09
Data Element Description:	The type of adjustment. Only applicable for transactions that are "adjusting" a former encounter transaction. These may be assigned by the MCO for credit/debit encounter transactions. R = A transaction that is the credit to reverse the adjusted transaction. N = A transaction that is the debit to replace the adjusted transaction.					
Validation Rules:	Required if Record Type is "C".					
Adjustment Type Detail	2 Fixed	A (00)	N	None	NA	D10
Data Element Description:	Specifies the type of adjustment. FC = An adjustment that fully reverses the adjusted transaction resulting in funds being paid back to the MCO from the provider. PC = An adjustment that partially reverses the adjusted transaction resulting in some funds being paid back to the MCO from the provider. NC = An adjustment that has no financial affect but changes demographic or other statistical data.					
Validation Rules:	Must be "FC", "NC" or "PC"					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Admit Start Care Date	10 Fixed	D (CCYY-MM-DD)	S			D96
Data Element Description:	The date the patient was admitted to the provider for inpatient care, outpatient service or start of care.					
Validation Rules:	Required on Institutional claims. Must be null for member share					
Admitting Diagnosis Code	6 Max	AN	N			D94
Data Element Description:	The ICD-9 diagnosis code provided at the time of admission as stated by the physician					
Validation Rules:	Must exist in the Master Lookup table. Must be null for member share					
Allowed Amount	15 (13,2) Max	N (-9999999999999.99)	S	None	NA	D61
Data Element Description:	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. The lesser of the Medicaid Rate, MCO Contracted Rate or the amount Billed/Charged by the Provider. Example the dollar amount of 35.5 can be sent as 35.5 or 35.50. Field size expanded to 18(15+decimal+2decimals) to comply with HIPAA					
Validation Rules:	Must be present for Encounter Transaction. Must be NULL for member share transactions					
Billing Provider First Name	25 Max	ANPlus	N	None	Billing_Provider_First_Name (AN, L=25)	D22
Data Element Description:	First name of the billing provider.					
Validation Rules:	(Highly encouraged to populate if the Billing Provider is an individual)					

SSI Managed Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Billing Provider ID	80 Max	ANPlus	S	None	Billing Provider Identifier (AN, L=80)	D20
Data Element Description:	The Provider's Employer ID, SSN, National Provider ID, or MCO specific ID.					
Validation Rules:	Required when MA Billing Provider ID field is not used otherwise it is optional.					
Billing Provider ID-Qualifier	2 Max	AN	S	None	ID Code Qualifier (AN, L=2)	D19
Data Element Description:	Qualifies what identification is used in the Billing Provider ID field. EIN = 24, SSN = 34, NPI = XX, or MCO specific = CO.					
Validation Rules:	Must be one of the following: 24, 34, XX or CO. Must be provided when Billing Provider ID is used.					
Billing Provider Middle Name	25 Max	ANPlus	N	None	Billing_Provider_Middle_ Name (AN, L=25)	D23
Data Element Description:	Full middle name of the billing provider.					
Validation Rules:						
Charges	15 (13,2) Max	N (-9999999999999.99)	S	None	Line Item Charge Amount (AN, L-18)	D56
Data Element Description:	The amount charged by the Provider. (This is the amount billed for this line item only. If multiple details are being billed on one claim do not enter the total claim billed amount). Example the dollar amount of 35.5 can be sent as 35.5 or 35.50. Field size expanded to 18(15+decimal+2decimals) to comply with HIPAA					
Validation Rules:	Must be provided for an Encounter transaction. Must be NULL for member share transactions.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Claim Type	2 Max	AN	S	None	NA	D97
Data Element Description:	Claim form used to fill out the claim					
Validation Rules:	Must be provided for an encounter transaction and must be NULL for member share. Must be one of the following values: DE = Dental, IN = Institutional, PH = Pharmacy, and PR = Professional					
Dispense As Written Ind	1 Fixed	AN (0)	S			D101
Data Element Description:	Indicator showing whether a brand name drug can be dispensed in lieu of a generic.					
Validation Rules:	Required on Pharmacy claims. Must be null for member share					
DRG	3 Max	N	N	None	DRG (N, L< =3)	D73
Data Element Description:	The national DRG code if applicable.					
Validation Rules:	Must exist in the Master Lookup table. Must be Null for Member Share.					
E Code	6 Max	AN	N			D95
Data Element Description:	External cause of injury. The ICD 9-CM code for the external cause of an injury, poisoning or adverse effect.					
Validation Rules:	Must exist in the Master Lookup table.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
From Statement Covers Date	10 Fixed	D (CCYY-MM-DD)	S			D92
Data Element Description:	The beginning service date of the period included on this bill					
Validation Rules:	Required on Institutional claims. Must be null for member share					
MA Billing Provider ID	8 Fixed	N (00000000)	S	None	NA	D18
Data Element Description:	Medicaid Billing Provider ID					
Validation Rules:	Required when Billing Provider ID field is not used otherwise it is optional. Must exist in the Master Lookup table.					
MA Rendering Provider ID	8 Fixed	N (00000000)	S	None	NA	D24
Data Element Description:	Medicaid Rendering Provider ID					
Validation Rules:	Must exist in the Master Lookup table. The MA Rendering Provider ID must not equal CMO based Org ID					
National Health Plan ID	80 Max	AN	N	None		D64
Data Element Description:	The national health plan identifier for this plan					
Validation Rules:						

SSI Managed Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
National Place of Service	2 Max	AN	S	None	Place of Service Code (AN, L=2)	D44
Data Element Description:	National Place of Service Code. (Refer to the place of service appendix in Part K of the WMAP handbook).					
Validation Rules:	Must exist in the Master Lookup table. Required on Professional claims. Must be NULL for member share.					
National Recipient ID	80 Max	AN	N	None		D65
Data Element Description:	The member's national subscriber identifier.					
Validation Rules:						
Original ID	80 Max	ANPlus	S	None	NA	D06
Data Element Description:	The unique ID assigned by the MCO to reference the first encounter that this and/or all subsequent adjustments were made from. This ID will always reference a Record_ID.					
Validation Rules:	Must exist on an Original record for that organization. Must exist on an adjustment record.					
Parent Record ID	80 Max	ANPlus	S	None	NA	D05
Data Element Description:	The unique ID assigned by the MCO to identify the record (claim detail line) that is being adjusted. This field is used only when adjusting an existing encounter record. In a credit/debit adjustment both the credit and debit transactions will reference the same transaction being adjusted.					
Validation Rules:	Used only when the record being submitted is an adjustment. Must match the Record_ID of the record being adjusted. Required if record being submitted is an adjustment.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Patient Discharge Status Code	2 Max	AN	S		NA	D78
Data Element Description:						
Validation Rules:	Must exist in the Master Lookup table. Required on Institutional Claims. Must be null for member share.					
Prescriber DEA Number	9 max	AN	S			D98
Data Element Description:	Drug Enforcement Agency number of the prescribing provider					
Validation Rules:	Required on pharmacy claims. Must be null for member share					
Prescription Number	8 max	AN	S			D99
Data Element Description:	Unique prescription number					
Validation Rules:	Required on Pharmacy claims. Must be null for member share					
Procedure Code	48 Max	AN	S	None	Procedure Code (AN, L=48)	D46
Data Element Description:	CPT, HCPCS, E-Codes, local, or national code. Local codes are approved State Local codes and not County or MCO generated local codes. HCPCS is a 5AN, NDC is 11AN and CPT is 5N					
Validation Rules:	Must exist in the Master Lookup table. Required if Revenue Code or ICD9 Procedure code is not provided.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Quantity	15 (12,3) Max	N (-999999999999.999)	S	None	Service Unit Count (AN, L=15)	D52
Data Element Description:	The quantitative measure of service rendered according to the service. Example the quantity of 35 1/2 can be sent as 35.5, 35.50 or 35.500.					
Validation Rules:	Must be present for Encounter Transactions. Must be NULL for member share transactions.					
Recipient Birth Date	10 Fixed	D (CCYY-MM-DD)	N	None	Birth Date (AN, L=25)	D71
Data Element Description:	Birth date for the Recipient/Subscriber					
Validation Rules:						
Recipient Death Date	10 Fixed	D (CCYY-MM-DD)	N	None	Death Date (AN, L=25)	D72
Data Element Description:	Death date for the Recipient/Subscriber					
Validation Rules:						
Recipient Middle Name	25 Max	ANPlus	N	None	Patient Middle Name (AN, L=25)	D33
Data Element Description:	Full middle name of recipient.					
Validation Rules:						

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Rendering Provider First Name	25 Max	ANPlus	N	None	Rendering_Provider_ First_Name (AN, L=25)	D28
Data Element Description:	First name of the rendering provider.					
Validation Rules:						
Rendering Provider ID	80 Max	ANPlus	S	None	Rendering Provider Identifier (AN, L=80)	D26
Data Element Description:	The Rendering Provider's Employer ID, SSN, National Provider ID, or MCO specific ID.					
Validation Rules:	Required if Rendering Provider Last Name is used.					
Rendering Provider ID-Qualifier	2 Max	AN	S	None	ID Code Qualifier (AN, L=2)	D25
Data Element Description:	Qualifies what identification is used in the Rendering Provider ID field. EIN = 24, SSN = 34, NPI = XX, or MCO specific = CO.					
Validation Rules:	Must be one of the following: 24, 34, XX or CO. Required if Rendering Provider ID is used.					
Rendering Provider Last Name	35 Max	ANPlus	S	None	Rendering_Provider_Last_Name (AN, L=35)	D27
Data Element Description:	Last name of the rendering provider.					
Validation Rules:	Required if Rendering Provider ID is used.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Rendering Provider Middle Name	25 Max	ANPlus	N	None	Rendering_Provider_ Middle_Name (AN, L=25)	D29
Data Element Description:	Full middle name of the rendering provider.					
Validation Rules:						
Revenue Code	4 Max	AN	S	None	NA	D51
Data Element Description:	A code which identifies a specific accommodation, ancillary service or billing calculation.					
Validation Rules:	Must exist in the Master Lookup table. Required if ICD9 Procedure Code or Procedure Code is not provded. Required if ICD9 Procedure Code is provided.					
To Statement Covers Date	10 Fixed	D (CCYY-MM-DD)	S			D93
Data Element Description:	The ending service date of the period included on this bill					
Validation Rules:	Required on Institutional claims. Must be null for member share					
Type of Bill Code	3 Max	AN	S			D91
Data Element Description:	A code indicating the specific type of bill. This three digit code requires 1 digit in each, in the following sequence: 1) Type of facility, 2) Bill Classification 3) Frequency. UB92 requires 3 fields and the HIPAA 837 only requires 2					
Validation Rules:	Must be on the master lookup table. Required on Institutional claims. Must be null for member share.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Unit Dose Ind	1 Fixed	AN(0)	S			D100
Data Element Description:	Indicator used when billing unit dose drugs.					
Validation Rules:	Required on Pharmacy claims. Must be null for member share					
Primary ANSI Reason Code	3 Max	AN	S	None	NA	D11
Data Element Description:	Primary standard ANSI reason code **(Claim Adjustment Reason Codes).**					
Validation Rules:	Must exist in the Master Lookup table. If the Claim Status field = "D" or if the amount paid differs from the amount charged a reason code must be provided in the Primary ANSI Reason Code field.					
Second ANSI Reason Code	3 Max	AN	N	None	NA	D12
Data Element Description:	Additional standard ANSI reason code **(Claim Adjustment Reason Codes).**					
Validation Rules:	Must exist in the Master Lookup table.					
Third ANSI Reason Code	3 Max	AN	N	None	NA	D13
Data Element Description:	Additional standard ANSI reason code **(Claim Adjustment Reason Codes).**					
Validation Rules:	Must exist in the Master Lookup table.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Fourth ANSI Reason Code	3 Max	AN	N	None	NA	D14
Data Element Description:	Additional standard ANSI reason code **(Claim Adjustment Reason Codes).**					
Validation Rules:	Must exist in the Master Lookup table.					
Fifth ANSI Reason Code	3 Max	AN	N	None	NA	D15
Data Element Description:	Additional standard ANSI reason code **(Claim Adjustment Reason Codes).** .					
Validation Rules:	Must exist in the Master Lookup table.					
Sixth ANSI Reason Code	3 Max	AN	N	None	NA	D16
Data Element Description:	Additional standard ANSI reason code **(Claim Adjustment Reason Codes).**					
Validation Rules:	Must exist in the Master Lookup table.					
Primary Diagnosis Code	30 Max	ANDot	N	None	Primary Diagnosis (AN, L=30)	D75
Data Element Description:	The full ICD-9 code describing the primary diagnosis (I.e. the condition established after study to be chiefly responsible for causing the admission or health care episode). The diagnosis code found on the Encounter.					
Validation Rules:	Must exist in the Master Lookup table. Must be NULL for member share. Diagnosis codes must be filled out sequentially without gaps. Primary Diagnosis Code is required for Institutional and Professional Claim types.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Second Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D35
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.					
Validation Rules:	Must exist in the Master Lookup table.					
Third Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D36
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.					
Validation Rules:	Must exist in the Master Lookup table.					
Fourth Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D37
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.					
Validation Rules:	Must exist in the Master Lookup table.					
Fifth Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D38
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.					
Validation Rules:	Must exist in the Master Lookup table.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Sixth Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D39
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.					
Validation Rules:	Must exist in the Master Lookup table.					
Seventh Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D40
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.					
Validation Rules:	Must exist in the Master Lookup table.					
Eighth Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D41
Data Element Description:	Additional ICD-9 code for conditions that may coexist at the time services were rendered.					
Validation Rules:	Must exist in the Master Lookup table.					
Ninth Diagnosis Code	30 Max	ANDot	N	None	Additional Diagnosis (AN, L=30)	D77
	Additional ICD-9 code for conditions that may coexist at the time services were rendered.					
Validation Rules:	Must exist in the Master Lookup table.					

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Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Primary ICD9 Procedure Code	30 Max	AN	S		NA	D79
Data Element Description:	The code that identifies the primary procedure performed during the period covered by this encounter.					
Validation Rules:	Must exist in the Master Lookup table. Required if Procedure Code Or Revenue Code is not provided. If ICD9 Procedure date is provided, then the coresponding code must be provided.					
Primary ICD9 Procedure Date	10 Fixed	D (CCYY-MM-DD)	S		NA	D85
Data Element Description:	The date the primary procedure was performed during the period covered by this encounter.					
Validation Rules:	If the ICD9 Procedure Code is Provided, the corresponding ICD9 Procedure date must be provided					
Second ICD9 Procedure Code	30 Max	AN	S		NA	D80
Data Element Description:	The code that identifies additional procedures performed during the period covered by this encounter.					
Validation Rules:	Must exist in the Master Lookup table. If ICD9 Procedure date is provided, then the coresponding code must be provided.					
Second ICD9 Procedure Date	10 Fixed	D (CCYY-MM-DD)	S		NA	D86
Data Element Description:	The date the additional procedure was performed during the period covered by this encounter.					
Validation Rules:	If the ICD9 Procedure Code is Provided, the corresponding ICD9 Procedure date must be provided					

SSI Managed Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Third ICD9 Procedure Code	30 Max	AN	S		NA	D81
Data Element Description:	The code that identifies additional procedures performed during the period covered by this encounter.					
Validation Rules:	Must exist in the Master Lookup table. If ICD9 Procedure date is provided, then the coresponding code must be provided.					
Third ICD9 Procedure Date	10 Fixed	D (CCYY-MM-DD)	S		NA	D87
Data Element Description:	The date the additional procedure was performed during the period covered by this encounter.					
Validation Rules:	If the ICD9 Procedure Code is Provided, the corresponding ICD9 Procedure date must be provided					
Fourth ICD9 Procedure Code	30 Max	AN	S		NA	D82
Data Element Description:	The code that identifies additional procedures performed during the period covered by this encounter.					
Validation Rules:	Must exist in the Master Lookup table. If ICD9 Procedure date is provided, then the coresponding code must be provided.					
Fourth ICD9 Procedure Date	10 Fixed	D (CCYY-MM-DD)	S		NA	D88
Data Element Description:	The date the additional procedure was performed during the period covered by this encounter.					
Validation Rules:	If the ICD9 Procedure Code is Provided, the corresponding ICD9 Procedure date must be provided					

SSI Managed Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
Fifth ICD9 Procedure Code	30 Max	AN	S		NA	D83
Data Element Description:	The code that identifies additional procedures performed during the period covered by this encounter.					
Validation Rules:	Must exist in the Master Lookup table. If ICD9 Procedure date is provided, then the coresponding code must be provided.					
Fifth ICD9 Procedure Date	10 Fixed	D (CCYY-MM-DD)	S		NA	D89
Data Element Description:	The date the additional procedure was performed during the period covered by this encounter.					
Validation Rules:	If the ICD9 Procedure Code is Provided, the corresponding ICD9 Procedure date must be provided					
Sixth ICD9 Procedure Code	30 Max	AN	S		NA	D84
Data Element Description:	The code that identifies additional procedures performed during the period covered by this encounter.					
Validation Rules:	Must exist in the Master Lookup table. If ICD9 Procedure date is provided, then the coresponding code must be provided.					
Sixth ICD9 Procedure Date	10 Fixed	D (CCYY-MM-DD)	S		NA	D90
Data Element Description:	The date the additional procedure was performed during the period covered by this encounter.					
Validation Rules:	If the ICD9 Procedure Code is Provided, the corresponding ICD9 Procedure date must be provided					

SSI Managed Care Encounter Reporting 2.5 --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, ANDot)	Is data Required?	Default Value	HIPAA (837) name and characteristics	ID#
First Modifier Code	2 Max	AN	N	None	Procedure Code Modifier 1 (AN, L=2)	D47
Data Element Description:	Two digit modifier code for the procedure code.					
Validation Rules:	Must exist in the Master Lookup table. Modifiers must be filled sequentially without gaps.					
Second Modifier Code	2 Max	AN	N	None	Procedure Code Modifier 2 (AN, L=2)	D48
Data Element Description:	Additional two digit modifier code.					
Validation Rules:	Must exist in the Master Lookup table.					
Third Modifier Code	2 Max	AN	N	None	Procedure Code Modifier 3 (AN, L=2)	D49
Data Element Description:	Additional two digit modifier code.					
Validation Rules:	Must exist in the Master Lookup table.					
Fourth Modifier Code	2 Max	AN	N	None	Procedure Code Modifier 4 (AN, L=2)	D50
Data Element Description:	Additional two digit modifier code.					
Validation Rules:	Must exist in the Master Lookup table.					

Information regarding Data Type

AN	Alpha numeric
ANPlus	Alpha numeric + special characters
ANDot	Alpha numeric + period
A	Alpha
N	Numeric
D	Data

Information regarding length

(000)	fixed length
(999)	variable length

Information regarding required field

Y	Yes, Data is required in this field for Original or Change New transactions
N	No, Data is not required in this field
S	Situational, Data is required in this field only when certain other criteria is met

Please note, the DD does not specify the severity of the edit. In most cases, it makes sense to set the severity to batch accept or batch reject. But, for business reasons, it may have been set to a Warning

Validation rule

This information is limited to business decisions and whether the data is checked against a master table or domain. We do not go into parser or data integrity validations.

Changed date	Item changed
4/26/2005	(First draft)